DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 0 31 — 0 3 4

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

7. FEDERAL BUDGET IMPACT
a. FFY 04 $ cost savings (12.6 million)
b. FFY 05 $ (12.6 million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Pages 3, 3A, 4, 5, 5A, 6, 7, 8, 16, 16A, 17, 18, 19, 19A, 23, 23A, 24, 35, 35A, 42, 43

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Pages: 3, 3A, 4, 5, 5, 7, 8, 16, 16A, 17, 18, 19, 19A, 23, 23A, 24, 35, 35A, 42, 43.

10. SUBJECT OF AMENDMENT
Changes to nursing facility case mix reimbursement methodology.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
Melanie Bella

13. TYPED NAME
Melanie Bella

14. TITLE
Assistant Secretary - OMPP

15. DATE SUBMITTED
December 29, 2003

16. RETURN TO
MS07
Melanie Bella, Assistant Secretary
Office of Medicaid Policy and Planning
402 W. Washington Street, Room W382
Indianapolis, Indiana 46204
ATTN: Tracy Brunner

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: SEP - 3 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Carmen Keller

22. TITLE: CMSC Acting Deputy Director CMSO

23. REMARKS:

FORM CMS-179 (07/92)

Instructions on Back

(10) Working capital interest.

(11) State gross receipts taxes.

(12) Utilization review costs.

(13) Liability insurance.

(14) Management and other consultant fees.

(15) Qualified mental retardation professional (QMRP).

(b) As used in this rule, "allowable per patient day cost" means a ratio between allowable variable cost and patient days using each provider's actual occupancy from the most recently completed desk reviewed annual financial report, plus a ratio between allowable fixed costs and patient days using the greater of the minimum occupancy requirements as contained in this rule, or each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report.

(c) As used in this rule, "annual financial report" refers to a presentation of financial data, including appropriate supplemental data, and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.

(d) As used in this rule, "average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable variable cost (including any applicable inflation adjustment) shall be computed on a statewide basis using each provider's actual occupancy from the most recently completed desk reviewed annual financial report. The average allowable fixed costs (including any applicable inflation adjustment) shall be computed on a statewide basis using an occupancy rate equal to the greater of the minimum occupancy requirements as contained in this rule, or each provider's actual occupancy rate from the most recently completed desk reviewed annual financial report. The average allowable cost of the median patient day shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(e) As used in this rule, "average historical cost of property of the median bed" means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

(f) As used in this rule, "calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(g) As used in this rule, "capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property Insurance

(h) As used in this rule, "case mix index" (CMI) means a numerical value score that describes the relative resource use for each resident within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

(i) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(j) As used in this rule, "children's nursing facility" means a nursing facility that has twenty-five percent (25%) or more of its residents who are under the chronological age of twenty-one (21) years, and has received written approval from the office to be designated as a children's nursing facility.

(k) As used in this rule "delinquent MDS resident assessment" means an assessment that is greater than one hundred thirteen (113) days old, as measured by the R2b date field on the MDS. This determination is made on the fifteenth day of the second month following the end of a calendar quarter.

(l) As used in this rule, "desk review" means a review and application of these regulations to a provider submitted annual financial report including accompanying notes and supplemental information.

(m) As used in this rule, "direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all:

(1) nursing and nursing aide services;

(2) nurse consulting services;

(3) pharmacy consultants;

(4) medical director services;

(5) nurse aide training;

(6) medical supplies;

(7) oxygen; and

(8) medical records costs.

(n) As used in this rule, "fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(o) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(p) As used in this rule "fixed costs" means the portion of each rate component that shall be subjected to the minimum occupancy requirements as contained in this rule. The following percentages shall be multiplied by total allowable costs to determine allowable fixed costs for each rate component:

Rate Component	Fixed Cost Percentage
Direct Care	25%
Indirect Care	37%
Administrative	84%
Capital	100%

(q) As used in this rule, "forms prescribed by the office" means cost reporting forms provided by the office or substitute forms that have received prior written approval by the office.

(r) As used in this rule, "general line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(s) As used in this rule, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(t) As used in this rule, "incomplete MDS resident assessment" means an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(u) As used in this rule, "indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable

indirect patient care services and supplies, including prorated employee benefits based on salaries and wages. Indirect care services and supplies include the following:

(1) Allowable dietary services and supplies.

(2) Raw food.

(3) Patient laundry services and supplies.

(4) Patient housekeeping services and supplies.

(5) Plant operations services and supplies.

(6) Utilities.

(7) Social services.

(8) Activities supplies and services.

(9) Recreational supplies and services.

(10) Repairs and maintenance.

(v) As used in this rule, "minimum data set (MDS)" means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration.

(w) As used in this rule, "medical and nonmedical supplies and equipment" include those items generally required to assure adequate medical care and personal hygiene of patients.

(x) As used in this rule, "normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average case mix index (CMI) for all residents.

(y) As used in this rule, "office" means the office of Medicaid policy and planning.

(z) As used in this rule, "ordinary patient-related costs" means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

(aa) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(bb) As used in this rule, "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(cc) As used in this rule, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

(dd) As used in this rule, "RUG-III resident classification system" means the resource utilization group used to classify residents. When a resident classifies into more than one (1) RUG III group, the RUG III group with the greatest CMI will be utilized to calculate the facility-average CMI and facility-average CMI for Medicaid residents.

(ee) As used in this rule, "therapy component" means the portion of each facility's direct costs for therapy services, including any employee benefits prorated based on total salaries and wages, rendered to Medicaid residents that are not reimbursed by other payers, as determined by this rule.

(ff) As used in this rule, "unit of service" means all patient care included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(gg) As used in this rule, "unsupported MDS resident assessment" means an assessment where one (1) or more data items that are required to classify a resident pursuant to the RUG-III resident classification system are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15, and such data items result in the assessment being classified into a different RUG-III category.

(hh) As used in this rule, "untimely MDS resident assessment" means a significant change MDS assessment, as defined by CMS' Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly; or a full or quarterly MDS assessment that is not completed as required by 405 IAC 1-15-6(a) following the conclusion of all physical therapy, speech therapy, and occupational therapy.

405 IAC 1-14.6-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Sec. 3. (a) Generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing change of provider transactions unless otherwise prescribed by this document or 405 IAC 1-14.6.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit indicates that the provider's records are inadequate to support data submitted to the office and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and notice is sent to the office by the provider. However, the office may:

(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;

(2) document such adjustments in a finalized exception report; and

initial interim rate effective date in which the provider has a minimum of six (6) months of actual historical data.

(c) In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee, or any change in control, a completed Checklist of Management Representations Concerning Change in Ownership shall be submitted to the office or its contractor. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office or its contractor.

405 I AC 1-14.6-6 Active providers; rate review

Sec. 6. (a) The normalized average allowable cost of the median patient day for the direct care component, and the average allowable cost of the median patient day for the indirect, administrative, and capital components, shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.

(b) The normalized allowable per patient day cost for the direct care component, and the allowable per patient day costs for the therapy, indirect care, administrative, and capital components shall be established once per year for each provider based on the annual financial report.

(c) The rate effective date of the annual rate review shall be the first day of the second calendar quarter following the provider's reporting year end.

(d) Subsequent to the annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

(e) The case mix index for Medicaid residents in each facility shall be updated each calendar quarter and shall be used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(f) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).